Behavioral Health Payment Reform Workgroup
2.4.20 Meeting Summary

The Department of Health Care Services (DHCS) held the second Behavioral Health Payment Reform workgroup meeting February 4. The third and final Behavioral Health Payment Reform workgroup will take place on February 27, 2020.

The meeting was attended by DHCS staff, workgroup members, and members of the public. Molly Brassil from Harbage Consulting facilitated the meeting and Lindy Harrington was the DHCS lead presenter.

This meeting focused on the following topics and also included presentations from San Diego and Alameda county representatives. A full agenda can be found here.

- An overview of the current physical health rate setting methodologies and intergovernmental transfers;
- An overview of the proposed rate setting methodology; and
- Public comment on the above topics.

Discussion Summary

The meeting began with a presentation from Andy Pease, Tabatha Lang, and Lavonne Lucas from San Diego County. The presenters walked through a flow chart following a beneficiary seeking specialty mental health services from the phone screening to discharge. The flow chart also shows local service codes and whether they crosswalk to a Current Procedural Terminology (CPT) code. Next, the presenters from San Diego walked through a flow chart describing the specialty mental health billing process from the provision of services to receiving payments from DHCS. From start to finish, this process spans across an average of 60 days. DHCS acknowledged that this process is not as straightforward in the substance use disorder (SUD) system of care, so payment reform implementation may be on different timelines.

- Below is a summary of comments made by workgroup members:

- Call to develop a crosswalk between Healthcare Common Procedure Coding System (HCPCS) and CPT codes.
- Local service codes are important to counties because they break the HCPCS codes into discreet types of services.
- While San Diego has a monthly billing cycle, other counties may have different billing cycles.

Next, DHCS provided an overview of rate methodologies used on the physical health side. These methodologies were presented to provide examples of rate setting processes that DHCS has experience with and are meant to inform the conversation about establishing a rate methodology for county BH services. DHCS acknowledged that there are pros and cons to each and the county BH financial structures add complexity. See slides here (6-12).

- Below is a summary of the dialogue between workgroup members and DHCS:
  - Diagnosis-Related Group (DRG) rates start with historical data of bucketed costs to establish a base payment. Software is used to cost out and apply adjustors based on market-based information.
  - Peer groupings are used across facility types.
  - Some counties apply different reimbursement arrangements to different provider types. Counties would appreciate the ability to retain this local flexibility.

Next, DHCS provided an overview of intergovernmental transfers (IGTs), and the benefits and challenges. See slides here (13-17).

- Below is a summary of the dialogue between workgroup members and DHCS:
  - Workgroup members flagged concerns regarding the proposed Medicaid Fiscal Accountability Rule. DHCS still believes the BH payment reform proposal is the best path forward for California in light of the proposed regulations.
  - Counties carry financial liabilities across fiscal years given the current audit and reconciliation process. Prior to implementation, there was a call to have this backlog addressed. DHCS acknowledged that they are continuing to look for ways to improve and streamline the process, but it is not realistic to say all historical risk will be addressed prior to implementation of the new methodology.

Next, DHCS introduced the proposed rate setting methodology for county BH services. See slides here (18-37) and the document illustrating examples of cash flow impact for shift from Certified Public Expenditures (CPE) to IGT.

- Below is a summary of the dialogue between workgroup members and DHCS on slides 18-26:
  - Regarding the first question on slide 26, most workgroup members agreed that the rates and codes should be different across the MH and SUD delivery systems in the beginning, but overtime as proposed changes to medical necessity and integration go into effect, the rates and codes should be integrated.
  - Regarding the second question on slide 26, several members called for more information and greater clarity on how travel time and administrative costs would be built into the rates. Some county representatives acknowledged that they would be able to provide data about travel time to DHCS to inform the rate setting process.
  - Call for a master billing manual to ensure consistency across counties.
  - Calls to ensure the rates do not inadvertently create perverse incentives and/or exacerbate the bifurcation between licensed vs. non-licensed professions and clinical vs. non-clinical services.
- Below is a summary of the dialogue between workgroup members and DHCS on slides 27-28:
  - Administrative and utilization review/quality assurance (UR/QA) costs would be informed by county responsibilities outlined in the contract.
  - Several workgroup members expressed cautious interest in the proposed per utilizer per month (PUPM) for administrative and UR/QA as there is variation across counties and how utilization driven reimbursement would impact fixed costs like county staffing levels.
- Below is a summary of the dialogue between workgroup members and DHCS on slides 29-30:
  - Regarding the first question on slide 30, several workgroup members agreed that an annual rate update is appropriate but would also appreciate an opportunity for an interim rate review in case there are any major discrepancies, particularly in the early years of implementation.
  - Regarding the second question on slide 30, several workgroup members agreed that at least 3-5 years of annual cost information would provide a good trend, with the assumption that there is no

    reconciliation. It was acknowledged that on the SUD side, counties may not have access to enough historical data to inform the rates.
  - Regarding the third question on slide 30, three years was the recommendation from several workgroup members.
  - DHCS could also consider implementing a standard rate and an incentive rate. If set benchmarks are achieved, entities would have access to the incentive rate. Could be a way to account for variability while promoting standardization.
- Below is a summary of the dialogue between workgroup members and DHCS on slides 31-37
  - Due to being short on time, DHCS encouraged workgroup members to send in their feedback about preference between IGT and county reimbursement options #1 vs. #2 and the important data points to consider.
  - One workgroup member voiced support of option #2 although the reimbursement timing would likely be delayed a month.
  - This proposed rate setting methodology and IGT process is between DHCS and the counties. Counties would still have flexibility at the local level to work on reimbursement and incentive arrangements with their provider networks.

Next, Rebecca Gebhart, Cecilia Serrano, and Rickie Michelle Lopez from Alameda County presented on their Behavioral Health Payment Transformation. See slides here.

Finally, members of the public were invited to comment.

- Below is a summary of public comment:
  - Call to ensure the cost of translation and linguistic competency are included in the rate setting methodology.
  - Concern about implications on the flexibility of using Mental Health Services Act (MHSA) funds under this proposed methodology.

Next Steps for DHCS

The Behavioral Health Payment Reform Workgroup will convene again on February 27, 2020.